		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023176

Facility Name: Flora Manor

Address: East 12th Street (Number) Flora, IL (City) 62839 (Zip Code)

County: Clay

Telephone Number: (618) 662-8494 **Fax #** (618) 662-9519

IDPA ID Number: 37-1018486001

Date of Initial License for Current Owners: 12/01/76

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (c) 3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Angela Simmons **Telephone Number:** (618) 548-0309

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/00 to 09/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) John V. Kolmer
(Title) President

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Gary S. Malawy, CPA, Partner
(Firm Name & Address) Krehbiel & Associates, 125 N. 11th Street Mt. Vernon, IL 62864
(Telephone) (618) 244-2666 Fax # (618) 244-2372

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	59	Intermediate/DD	59	21,535	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	59	TOTALS	59	21,535	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	21,049			21,049	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,049			21,049	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.74%

D. How many bed-hold days during this year were paid by Public Aid?
253 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 12/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/17/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/01 Fiscal Year: 09/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	137,309	13,405	3,864	154,578	(39)	154,539		154,539			1
2	Food Purchase		133,554		133,554	(5,342)	128,212		128,212			2
3	Housekeeping	62,825	15,250		78,075		78,075		78,075			3
4	Laundry	54,163	19,520		73,683		73,683		73,683			4
5	Heat and Other Utilities			42,554	42,554		42,554		42,554			5
6	Maintenance	22,024	16,310	13,209	51,543		51,543	2,079	53,622			6
7	Other (specify):* Garbage Pickup			2,407	2,407		2,407		2,407			7
8	**TOTAL General Services**	276,321	198,039	62,034	536,394	(5,381)	531,013	2,079	533,092			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	612,198	15,415	17,136	644,749	(130)	644,619		644,619			10
10a	Therapy			10,391	10,391	(75)	10,316		10,316			10a
11	Activities	59,683	14,056		73,739		73,739		73,739			11
12	Social Services	6,490	242		6,732		6,732		6,732			12
13	Nurse Aide Training	7,665	175		7,840		7,840		7,840			13
14	Program Transportation			2,448	2,448	(1,806)	642		642			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	686,036	29,888	29,975	745,899	(2,011)	743,888		743,888			16
	C. General Administration											
17	Administrative	102,862			102,862		102,862		102,862			17
18	Directors Fees			5,700	5,700		5,700		5,700			18
19	Professional Services			345,425	345,425		345,425		345,425			19
20	Dues, Fees, Subscriptions & Promotions			3,223	3,223		3,223		3,223			20
21	Clerical & General Office Expenses	72,545	10,081	6,889	89,515		89,515		89,515			21
22	Employee Benefits & Payroll Taxes			229,872	229,872	5,342	235,214		235,214			22
23	Inservice Training & Education			115	115	244	359		359			23
24	Travel and Seminar			1,462	1,462		1,462		1,462			24
25	Other Admin. Staff Transportation			12,923	12,923		12,923		12,923			25
26	Insurance-Prop.Liab.Malpractice			13,434	13,434		13,434		13,434			26
27	Other (specify):* Donation			23,757	23,757		23,757	(23,757)				27
28	**TOTAL General Administration**	175,407	10,081	642,800	828,288	5,586	833,874	(23,757)	810,117			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,137,764	238,008	734,809	2,110,581	(1,806)	2,108,775	(21,678)	2,087,097			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Flora Manor #0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			63,793	63,793		63,793	(6,133)	57,660			30
31	Amortization of Pre-Op. & Org.			2,596	2,596		2,596		2,596			31
32	Interest			18,528	18,528		18,528	(18,528)				32
33	Real Estate Taxes			4,189	4,189		4,189	(4,189)				33
34	Rent-Facility & Grounds			10,800	10,800		10,800		10,800			34
35	Rent-Equipment & Vehicles			10,878	10,878		10,878		10,878			35
36	Other (specify):* **Unrealized loss**			91,082	91,082		91,082	(91,082)				36
37	**TOTAL Ownership**			201,866	201,866		201,866	(119,932)	81,934			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,806	1,806		1,806			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,745	127,745		127,745		127,745			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			127,745	127,745	1,806	129,551		129,551			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,137,764	238,008	1,064,420	2,440,192		2,440,192	(141,610)	2,298,582			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,133)	30		9
10	Interest and Other Investment Income	(18,528)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(23,757)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(93,192)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (141,610)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (141,610)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 1,806	L14	38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,806		47

STATE OF ILLINOIS

Flora Manor

ID# **0023176**

Report Period Beginning: **10/01/00**

Ending: **09/30/01**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Flora Manor # 0023176 **Report Period Beginning:** 10/01/00 **Ending:** 09/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(23,757)	0	0	0	0	0	0	0	0	0	0	(23,757)	27
28	**TOTAL General Administration**	(23,757)	0	0	0	0	0	0	0	0	0	0	(23,757)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,757)	0	0	0	0	0	0	0	0	0	0	(23,757)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Flora Manor** **#** **0023176** **Report Period Beginning:** **10/01/00** **Ending:** **09/30/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,133)	0	0	0	0	0	0	0	0	0	0	(6,133)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,528)	0	0	0	0	0	0	0	0	0	0	(18,528)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(24,661)	0	0	0	0	0	0	0	0	0	0	(24,661)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(48,418)	0	0	0	0	0	0	0	0	0	0	(48,418)	45

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached 6a						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V		None		Clay County Horizon Center	0.00%			2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Kolmer	Director	Board Member	0.00	0	3	7.00	Director Fee	$ 2,600	L18,C3	1
2	Marsha Taylor	Director	Board Member	0.00	0	1	3.00	Director Fee	1,700	L18,C3	2
3	Raymond Halbrook	Director	Board Member	0.00	0	1	3.00	Director Fee	1,400	L18,C3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 5,700		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Clay County Horizon Center
Street Address: East 12th Street
City / State / Zip Code: Flora, IL 62839
Phone Number: (618) 662-8494
Fax Number: (618) 662-9519

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	American Ntnl Bank "Bond"		X	Purchase Facility	$7,872.00	11/18/88	$ 790,000	$ 154,200	08/15/03	7.4000	$ 18,528	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interest Income Flora Manor										(18,528)	6
7												7
8												8
9	TOTAL Facility Related				$7,872.00		$ 790,000	$ 154,200			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 790,000	$ 154,200			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	3,031	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,031	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	1,158	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	4,189	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	26,714	8
	1997	1,271	9
	1998	1,386	10
	1999	1,487	11
	2000	1,544	12

Non-care related real estate tax paid was $3031. (1999 bill paid in 2000) Non-care accrual was $1158. (1544 x 9/12)

Real estate tax exemption received for the care-related portion of Flora Manor's real estate.

Total non-care expense ($1487 + $1544 + $1158 = $4189) was adjusted off the cost report on Line 33, Column 8 of Schedule V. (Page 4 of the cost report)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Flora Manor COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0023176

CONTACT PERSON REGARDING THIS REPORT Angela Simmons

TELEPHONE (618) 548-0309 FAX #: (618) 548-3720

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-00-008-840	King addition lot 6	$ 266.00	$
2.	11-00-008-815	Kings addition lot 2/4	$ 200.00	$
3.	11-00-008-820	Kings addition lot 3	$ 134.00	$
4.	11-00-008-825	Kings addtion lt 4	$ 134.00	$
5.	11-00-008-845	Kings addtion lots 7/8	$ 534.00	$
6.	08-24-200-004	S 1/2 NE & SE NW	$ 276.00	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,544.00	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,240 B. General Construction Type: Exterior Masonry/Brick Front Frame 1 hr. fire rate plaster Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Farm land 120 acres of which all related costs have been adjusted out of this cost report, including real estate taxes.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	90,000	1989	$ 23,080	1
2					2
3	TOTALS	90,000		$ 23,080	3

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	59		1988	1968	$ 692,310	$ 21,978	31.5	$ 21,978	$	$ 282,968	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodeling			1983	3,343		15			3,343	9
10	Covering, blinds, painting			1984	8,970		15			8,970	10
11	Remodeling/ painting			1985	6,940		15			6,940	11
12	Remodeling			1986	1,287		10			1,287	12
13	Remodeling, floor, tile			1987	45,273	2,512	15	2,512		43,866	13
14	Fixtures, door			1988	2,921	146	20	146		1,972	14
15	Door frame			1989	788	30	31.5	30		207	15
16	Parking lot			1991	22,176	1,478	15	1,478		15,276	16
17	Doors, vinyl, patio			1993	15,750	600	15	600		11,658	17
18	Windows/ shower			1993	10,441	696	15	696		5,453	18
19	Roof, boiler, contracting			1994	9,396	564	15	564		4,160	19
20	Rock driveway			1994	4,540		5			4,540	20
21	Garage			1994	9,154	610	15	610		4,272	21
22	Tile, windows, lockset			1995	6,261	417	15	417		2,609	22
23	Alarm system upgrade			1995	8,225	411	20	411		2,468	23
24	Furnace, ductwork			1996	5,063	338	15	338		1,969	24
25	Water heater/ installation			1996	1,915	192	10	192		1,053	25
26	Floor covering			1996	1,007	67	15	67		358	26
27	Bathroom vents, shower, ventilation			1996	3,812	254	15	254		1,313	27
28	Remodel two bathrooms into showers			1996	13,803	920	15	920		4,754	28
29	Plumbing throughout facility			1996	46,034	1,841	25	1,841		9,667	29
30	Bathroom remodeling men's wing			1996	7,283	486	15	486		2,509	30
31	Condenser/ installation 5 ton			1996	1,317	88	15	88		498	31
32	Trees, tree planting			1996	1,955	195	10	195		1,092	32
33	Remodeling			1997	7,492		7			7,492	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Bathroom remodeling/ women's wing	1996	$ 2,809	$ 187	15	$ 187	$	$ 889	37
38	Bathroom floor/ Women's	1997	659	44	15	44		180	38
39	Sprinkler line for women's bathroom	1997	1,786	119	15	119		556	39
40	Bathroom remodeling/ plumbing women's wing	1997	22,740	910	25	910		4,169	40
41	Floor, walls, Women's wing remodeling	1997	8,284	552	15	552		2,577	41
42	Ceiling/ women's bathroom	1997	1,344	90	15	90		426	42
43	Fence	1998	1,700	170	10	170		524	43
44	Remodel outside of building	1998	3,200	128	25	128		480	44
45	Central air conditioner/condenser	1998	4,025	268	15	268		827	45
46	Storage building remodeling	1998	22,341	894	25	894		2,755	46
47	Remodel front entrance	1999	4,107	274	15	274		799	47
48	Siding, guttering, roof repair	1999	13,659	911	15	911		2,656	48
49	Security system addition	1999	2,089	139	15	139		406	49
50	Driveway concrete	1999	1,730	115	15	115		327	50
51	Outside furnace/ air conditioner	1999	5,146	515	10	515		1,415	51
52	Outside painting/ Fence repair	1999	2,827	283	10	283		682	52
53	Kitchen cabinets & installation	1999	4,368	291	15	291		607	53
54	Bathroom remodeling	2000	5,336	356	15	356		534	54
55	Patient middle room remodeling	2001	2,800	200	10	200		200	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,048,406	$ 40,269		$ 40,269	$	$ 451,703	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 240,252	$ 12,194	$ 12,194	$	10	$ 177,544	71
72	Current Year Purchases	2,145	153	153		10	153	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 242,397	$ 12,347	$ 12,347	$		$ 177,697	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Transportation	2000 Dodge Liftwagon Van	2000	$ 37,694	$ 3,769	$ 3,769	$	4	$ 3,769	76
77	Facility Transportation	1998 Dodge Van	2001	12,750	1,275	1,275		4	1,275	77
78										78
79										79
80	TOTALS			$ 50,444	$ 5,044	$ 5,044	$		$ 5,044	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,364,327	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,660	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,660	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 634,444	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: JACK WOODS
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Office	1987		03/09/92	3,600	5	Not	5
6	Storage Bld.	1998		08/01/98	7,200	5	Determinable	6
7	TOTAL				$ 10,800 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 03/09/92
    Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	09/30/2002	$ 10,800
13.	09/30/2003	$ 10,800
14.	09/30/2004	$ 10,800

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 2,878 Description: Dishwasher $2,878
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Activities/Patient Care	1992 Dodge Van (8mo)	$ 400.00	$ 3,200	17
18	Activities/Patient Care	1991 Plymouth	400.00	4,800	18
19					19
20					20
21	TOTAL		$ 800.00	$ 8,000	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 50

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			175		175
3	Classroom Wages	(a)		2,450		2,450
4	Clinical Wages	(b)		3,920		3,920
5	In-House Trainer Wages	(c)		1,295		1,295
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 7,840	$	$ 7,840
10	SUM OF line 9, col. 1 and 2	(e)	$ 7,840			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$ N/A		$	$		$ #VALUE!	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 412,646	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	341,610		3
4	Supply Inventory (priced at cost)	11,743		4
5	Short-Term Investments	777,378		5
6	Prepaid Insurance	16,809		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued interest	7,738		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,567,924	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	198,420		13
14	Buildings, at Historical Cost	702,252		14
15	Leasehold Improvements, at Historical Cost	346,154		15
16	Equipment, at Historical Cost	351,640		16
17	Accumulated Depreciation (book methods)	(669,612)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	38,946		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(33,537)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Note Receivable-CILA	95,031		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,029,294	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,597,218	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 20,222	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,144		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,792		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,158		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 105,316	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	154,200		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 154,200	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 259,516	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,337,702	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,597,218	$	48

***(See instructions.)**

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,427,339	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,427,339	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(89,637)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (89,637)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,337,702	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,262,617	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,262,617	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	10,474	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 10,474	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	73,903	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 73,903	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	1,806	28
28a	See attached pg 19a	1,755	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,561	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,350,555	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	536,394	31
32	Health Care	745,899	32
33	General Administration	828,288	33
	B. Capital Expense		
34	Ownership	201,866	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	127,745	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,440,192	40
41	**Income before Income Taxes (line 30 minus line 40)****	(89,637)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (89,637)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,008	2,080	$ 40,750	$ 19.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,170	9,618	137,693	14.32	3
4	Licensed Practical Nurses	374	374	5,120	13.69	4
5	Nurse Aides & Orderlies	40,785	42,137	307,028	7.29	5
6	Nurse Aide Trainees	910	910	6,370	7.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,651	1,731	16,977	9.81	9
10	Activity Assistants	5,192	5,352	42,706	7.98	10
11	Social Service Workers	208	208	6,490	31.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,703	3,799	35,132	9.25	14
15	Cook Helpers/Assistants	12,308	12,788	102,177	7.99	15
16	Dishwashers					16
17	Maintenance Workers	1,849	1,937	22,024	11.37	17
18	Housekeepers	7,158	7,374	62,825	8.52	18
19	Laundry	6,168	6,432	54,163	8.42	19
20	Administrator	2,520	2,600	60,680	23.34	20
21	Assistant Administrator					21
22	Other Administrative	1,334	1,352	42,182	31.20	22
23	Office Manager					23
24	Clerical	4,409	4,489	72,545	16.16	24
25	Vocational Instruction					25
26	Academic Instruction	140	140	1,295	9.25	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,126	8,397	121,607	14.48	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	108,013	111,718	$ 1,137,764 *	$ 10.18	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	105	$ 3,864	L1,C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	600	L10,C3	39
40	Physical Therapy Consultant	47	1,567	L10a,C3	40
41	Occupational Therapy Consultant	138	6,584	L10a,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	56	2,240	L10a,C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	120	8,400	L10,C3	47
48	Psychology Consultant	117	8,136	L10,C3	48
49	TOTAL (lines 35 - 48)	595	$ 31,391		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dayo Adenekan	Administrator	0	$ 60,680
Charlotte Watton	Admin/ Exec. Director	0	42,182
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 102,862

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Krehbiel & Associates	Accounting	$ 9,050
Health Care Management	Admin. Consulting Fees	336,300
Miscellaneous	Acctg/Data Processing	75
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 345,425

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,414
Unemployment Compensation Insurance	7,509
FICA Taxes	87,039
Employee Health Insurance	48,910
Employee Meals	5,342
Illinois Municipal Retirement Fund (IMRF)*	
Employee Vaccinations	329
Pension Contribution For Employees	53,772
Employee morale, miscellaneous benefits	899
TOTAL (agree to Schedule V, line 22, col.8)	$ 235,214

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,914
Health Care Worker Background Check (Indicate # of checks performed 23)	276
Dues, Books, Subscriptions	833
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,223

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	749
Seminar Expense	713
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,462

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/00 Ending: 09/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Interior Painting	Aug 99	$ 6,443	36 MO	$	$ 358	$ 2,148	$ 2,148	$ 1,789	$	$	$	$
2	Interior Painting	Sep 00	4,548	36 MO			126	1,516	1,516	1,390			
3	Interior Painting	Nov 00	1,613	36 MO				493	538	538	44		
4	Interior Painting	Aug 01	2,080	36 MO				116	693	693	578		
5	Interior Painting	Sep 01	3,302	36 MO				92	1,101	1,101	1,008		
6	Interior Painting	Aug 98	2,043	36 MO	114	681	681	567					
7	Interior Painting	Sep 98	4,680	36 MO	130	1,560	1,560	1,430					
8	Heating Repair & Maint.	Mar 99	2,770	36 MO		539	923	923	385				
9	Interior Painting	Jun 99	5,367	36 MO		596	1,789	1,789	1,193				
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 32,846		$ 244	$ 3,734	$ 7,227	$ 9,074	$ 7,215	$ 3,722	$ 1,630	$	$

Facility Name & ID Number Flora Manor # 0023176 **Report Period Beginning:** 10/01/00 **Ending:** 09/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line N/A

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES No NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 127,745
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 5,342 Has any meal income been offset against related costs? N/A Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. $ 1,806
c. What percent of all travel expense relates to transportation of nurses and patients? 16%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Krehbiel & Associates The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.